

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

11723

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County..... *St. Marys*
 City or town..... *Leonardtown Maryland*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *5 days*Hospital, institution, or street address where death occurred..... *St. Marys Hosp.**Leonardtown Maryland*How long in hospital or institution?..... *5 days*

3. (a) FULL NAME

Frances Ruth Brown

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

*Female White Married*6. (b) Name of husband or wife..... *Joseph Bennett Brown*

7. Birth date of deceased (mo., day, yr.)..... 6. (c) If alive, give age..... 74 years

Oct 17 - 1884

8. AGE: Years..... Months..... Days..... If less than one day.....

67 - 18 hrs. min.

9. Birthplace..... (Town, county, and state).....

St. George Island St. Marys Md.

10. Usual occupation.....

House wife

11. Industry or business

12. Name..... *Frances*13. Birthplace..... *St. Marys Co*14. Maiden name..... *Elizabeth Thomas*15. Birthplace..... *St. Marys Co*16. Informant..... *Jr. B. Brown*Address..... *St. George Island MD*17. Burial..... *Burial* Date thereof..... *Nov 6 1948*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... *St. Francis Xavier*Location..... *St. George Island Md*18. Funeral director..... *W. C. Hartings Sons*Address..... *Leonardtown Md*19. Date rec'd by registrar..... *11/5 48*

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *St. Marys*City or town..... *St. George Island*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Nov 4* 1948 at 10.20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Oct 30* 1948 to *Nov. 4* 1948and that I last saw her alive on *November 4* 1948

Immediate cause of death.....

Cerebral Hemorrhage

Due to.....

Chronic Hypertension

Due to.....

*over 10 yrs.*Other conditions..... *Tornal Bronchi-Pneumonia*(Include pregnancy within 3 months of death) *3 days.*

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

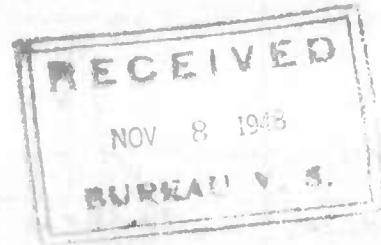
Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... *Robert J. Fuchs M.D.*

M. D. or other.....

Address..... *Leonardtown Md* Date signed..... *11/5/48*



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11724

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

St. Marys
Leonardtown, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Marys Hospital

How long in hospital or institution?

3. (a) FULL NAME

Mary Madeline Carberry

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Colored

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 8, 1903

6. (c) If alive, give age

years

8. AGE

Years

Months

Days

If less than one day

45

1

26

hrs.

min.

9. Birthplace

Leonardtown, St. Marys, Md.

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

Abed Carberry

12. Name

St. Marys County, Maryland

13. Birthplace

Sarah Morgan

14. Maiden name

St. Marys County, Maryland

15. Birthplace

Sarah Carberry

16. Informant

Leonardtown, Md.

Address

17. Burial

Date thereof Nov. 8, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Our Ladies Cemetery

Location

Medley's Neck, Maryland

18. Funeral director

J.W. Robinson Fun'l Home

Address

Leonardtown, Md.

19. Date rec'd by registrar

4 P. Gacealey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County St. Marys

City or town

Leonardtown (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

4 Nov

1948

3720

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 Aug

1948

to

4 Nov

1948

and that I last saw her alive on

3 Nov

1948

Immediate cause of death

Generalized carcinomatosis

Due to

Carcinoma, uterus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Roy Guyther, M.D.

Mechanicsville

4 Nov 1948

(M. D. or other)
Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11725
202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County *St. Marys*City or town *Chapman*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *7 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Jacobine O. Cook.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female *white* WidowedB. (b) Name of husband or wife *Bailey Cook*7. Birth date of deceased (mo., day, yr.) *May 24, 1864.*

6. (c) If alive, give age years

8. AGE: Years *84* Months *5* Days *17* If less than one day

hrs. min.

9. Birthplace *St. Marys Co. Md.*

(Town, county, and state)

10. Usual occupation *Hauswif -*

11. Industry or business

12. Name *Benjamin Ovens -*13. Birthplace *Md -*14. Maiden name *Not known -*

15. Birthplace

16. Informant *Obie Nelson -*Address *Chapman Md -*17. Burial, cremation, or removal, Which? *Burial* Date thereof *11/15/48*

(month) (day) (year)

Cemetery or crematory *Sacred Heart Cemetery*Location *Bushwood, Maryland -*18. Funeral director *Alexius C. Welch -*Address *Chapman Md*19. Date rec'd by Registrar *11/12/48* Address *Chapman*

(Date rec'd by Registrar) (Address)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *St. Mary's*City or town *Chapman*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 11 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Acute Cardiac failure 20 min. -

Due to

Chronic myocarditis -

Due to

Senile degeneration of old age

Other conditions

None -

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

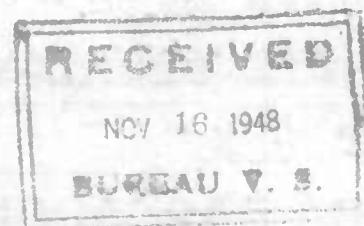
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Alexius C. Welch* M. D. or otherAddress *Chapman Maryland* Date signed *11/11/48*

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11727

CERTIFICATE OF DEATH

Reg. Dist. No. 282

The correct page

1. PLACE OF DEATH:

County.....

St. Marys

City or town.....

near St. Marys city

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Herbert Williams Dorsay

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife.....

Elizabeth Dorsay

7. Birth date of deceased (mo., day, yr.)

ABT. 1889

6. (c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

5 - 9

hrs.

min.

9. Birthplace

Pax Hall St. Marys Maryland

(Town, county, and state)

10. Usual occupation.....

Waterman

11. Industry or business

MOTHER FATHER

12. Name..... Parker Dorsay

13. Birthplace..... St. Marys

14. Maiden name..... Sola Dorsay

15. Birthplace..... St. Marys Co

16. Informant.....

Elizabeth Dorsay

Address..... St. Marys City

17. Burial

Cemetery or crematory..... St. James Cemetery

(Burial, cremation, or removal. Which?)

Date thereof..... Jul 6 1948

(month) (day) (year)

Location.....

Near St. Marys City

18. Funeral director..... W. C. Mathisly Son

Address..... Leonardtown Md

19. 11/5 48 Caucasian

(Date rec'd by registrar) 19

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... St. Marys

City or town..... near St. Marys city

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

213-22-0477

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 4

1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 30 1948 to Nov 4 1948

and that I last saw him alive on

Nov 3 1948

Immediate cause of death.....

Influenza pneumonia

Due to.....

Due to.....

Other condition..... Chronic interstitial

Nephritis

?

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

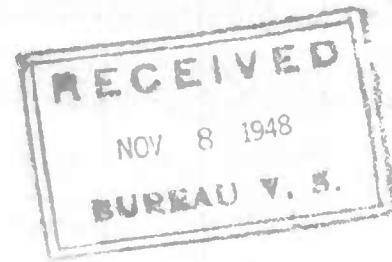
23. SIGNATURE..... E. L. Thompson

Address..... Lexington Park

M. D. or other

Date signed..... Nov 4 1948

6881
68
8/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11726

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH: St. Marys
 County.....
 City or town..... Leonardtown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, Institution, or street address where death occurred: St. Marys
 How long in hospital or institution?..... 2 days

1245
 2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... St. Marys
 City or town..... Hermansville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Philip Harrison Dyson
 4. Sex male | 5. Color or race white | 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1907

8. AGE: Years 41 Months | Days | If less than one day hrs. min.

9. Birthplace..... Maryland
 (Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

MOTHER FATHER
 12. Name..... Philip Dyson
 Maryland
 13. Birthplace.....
 14. Maiden name..... Francis Downes
 15. Birthplace..... Maryland

16. Informant..... Earl F. Dyson
 Address..... Hermansville Maryland

17. Burial..... Date thereof..... 11/17/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Holy Face
 Location..... Great Mills, Md.

18. Funeral director..... P. B. Robinson
 Address..... Leonardtown, Md.

19. Date recd by registrar..... 11/16 1948
 (Date recd by registrar) Cawley T Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1948 at 3:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1948 to Nov 14 1948 and that I last saw him alive on Nov 12 1948. Immediate cause of death Hernoscopy

DURATION

Due to..... Liver Protrusion
 Due to..... Cirrhosis (Portal)

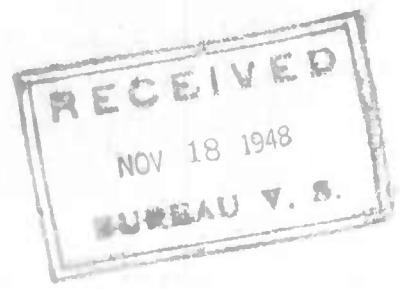
Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury..... Injured at work?

23. SIGNATURE..... Wm D. Boyd M.D. or other
 Address..... Leonardtown, Md. Date signed..... 11/17/48



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11728
282

1. PLACE OF DEATH:
 County St. Marys County Md.
 City or town U.S. Naval Air Station, Patuxent River
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year 8 months
 Hospital, institution, or street address where death occurred:
Dispensary, NAS, Patuxent River, Md.
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State Kentucky County Wolfe
 City or town Landsaw, Kentucky
(If outside city or town limits, write RURAL and give nearest town)
 Street No. Box 142
(If rural, give LOCATION)
 2.(a) If veteran, name war World War II

3. (a) FULL NAME

FAULKNER, Corbett Bruce

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife Unmarried

7. Birth date of deceased (mo., day, yr.) 11-3-24 6.(c) If alive, give age years

8. AGE: Years 23 Months 11 Days 29 If less than one day hrs. min.

9. Birthplace Landsaw, Kentucky
(Town, county, and state)

10. Usual occupation Mariner

11. Industry or business U. S. Navy

MOTHER FATHER
 12. Name Leonard Faulkner
 13. Birthplace Unknown

MOTHER FATHER
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Official Navy Records

Address

17. Transportation Date thereof 11/3/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or columbarium

Location Stanton, Kentucky

18. Funeral director P. B. Robinson's Funeral Home

Address Leonardtown, Md.

19. 11/3 1948 Causes Registrar

(Date rec'd by registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 November 19 48 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1:00 A.M. on 11-1 19 48 to 6:45 P.M. 11-1-48

and that I last saw him alive on 1 November 19 48

Immediate cause of death Hemorrhage, Traumatic, Intracranial

DURATION

Due to Fracture, Compound, Skull

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results Cong. Fract. of skull

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-1-48

Where did injury occur? California, St. Marys, Md. (City or town) (County) (State)

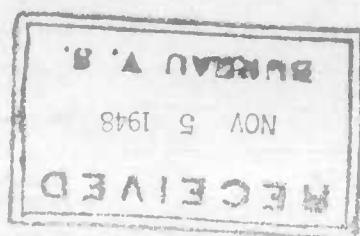
Injured at home, farm, industry, public place (where?) Highway #235

Means of injury Automobile Injured at work? No

23. SIGNATURE Paul Vaughan CAPT MC USN
 M.D. or other

Dispensary, U.S. Naval Air Station, Date signed 11-2-48

Address Patuxent River, Md.



11729

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County.....

City or town.....

St. Mary's
Towerville Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 90 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Eugene Tough

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white married

6. (b) Name of husband or wife

Virginia M. Tough

7. Birth date of deceased (mo., day, yr.)

April 28 - 1873

6. (c) If alive, give age 54 years

8. AGE:

Years
75Months
6Days
27If less than one day
hrs. min.

9. Birthplace

St. Leonardtown St. Mary's Md
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

Joseph S. Tough

12. Name

St. Mary's Co

13. Birthplace

Elizabeth Roache

14. Maiden name

St. Mary's Co

15. Birthplace

Mrs. Charles E. Tough

16. Informant

Towerville Maryland

Address

Burial

Date thereof
(month) (day) (year)
Nov 22 1948

Cemetery or crematory

Ladies Chapel

Location

Nac Leonardtown Md

18. Funeral director

W. C. Mattingly Son

Address

Leonardtown Md

19. (Date rec'd by registrar)

11/20 1948 Caucasian

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.....

County.....

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 19 1948 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15 1948 to Nov 19 1948

and that I last saw him alive on Nov 19 1948

Immediate cause of death

Coronary Thrombosis 4 days

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

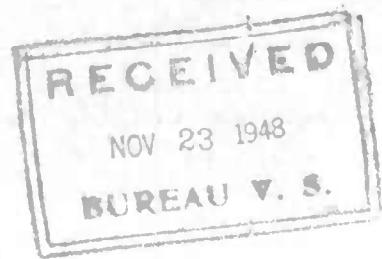
M

MARGIN RESERVED FOR BINDING

I

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11730

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County..... St. Marys

City or town..... Dameron

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ida Indiana Hammett

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female white

widowed

8.(b) Name of husband or wife.....

8.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) March 28, 1864

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

12. Name..... Ignatius Bohannan

13. Birthplace..... Maryland

14. Maiden name..... Martha Clark

15. Birthplace..... Maryland

16. Informant..... Mary K. Trossbach

Address..... Dameron, Md.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... 11/28/48

(month) (day) (year)

Cemetery or crematory..... St. James

Location..... St. James, Md.

18. Funeral director..... P. B. Robinson

Address..... Leonardtown, Md.

19. Nov. 21, 1948

(Date rec'd by registrar)

P. J. Beary M.D.
Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... St. Marys

City or town..... Dameron

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Nov 19 1948 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov 19 1948 to Nov 19 1948

and that I last saw her alive on Nov 19 1948

Immediate cause of death.....

Coronary occlusion
General arteriosclerosis

Due to.....

Due to.....

Other conditions.....

(include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

P. J. Beary M.D.
Great Mills, Md. Date signed 11-21-48

M. D. or other

RECEIVED

NOV 23 1943

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11731

CERTIFICATE OF DEATH

Reg. Dist. No. 28-2

1. PLACE OF DEATH:

County...

City or town...

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

30 min.

30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State...

City or town...

Street No...

2.(a) If veteran, name war.

County...

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

3. (a) FULL NAME

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

-

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 16 148

6.(c) If alive, give age..... years

8. AGE:

Years	Months	Days	If less than one day hrs.
			30 min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Dr. Peets Head

13. Birthplace

Md

14. Maiden name

Teresa Daugherty Head

15. Birthplace

Md

16. Informant

Dr. Peets Head

Address

Ballywood

Date thereof

11/16/48

(Burial, cremation, or removal, Which?)

Burial

Cemetery or crematory

St. Agnes

Location

Georgetown

18. Funeral director

Dr. Peets Head

Address

Ballywood

19. (Date rec'd by registrar)

11/16

19

Cause

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 16 48

at 11th A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 16 18th to Nov. 16 1948

and that I last saw him alive on Nov. 16 1948

Immediate cause of death

Asphyxia -
PneumoniaDue to
aspiration Pneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Frank A. Cacoulis M. D. or other

Address Georgetown Date signed 11/16/48

RECEIVED

NOV 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95a

11733

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County.....

St. Marys
Leonardtown MarylandCity or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Leonardtown Maryland

How long in hospital or institution?.....

A. F. D. # 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys

City or town..... Leonardtown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 117 F. D. # 1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

Robert Combe Laker

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White married

6.(b) Name of husband or wife..... Katharine C. Laker

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... 75 years

July 10 - 1871

8. AGE: Years Months Days It less than one day

77 3 23 hrs. min.

9. Birthplace..... Leonardtown St. Marys Maryland

(Town, county, and state)

10. Usual occupation..... Fisherman

11. Industry or business..... same

12. Name..... William A. Laker

13. Birthplace..... St. Marys Co

14. Maiden name..... Sue Combe

15. Birthplace..... St. Marys Co

16. Informant..... Mr. Katharine C. Laker

Address..... Leonardtown Maryland

Burial..... Cemetery Date thereof..... Nov. 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Alphonsus Cemetery

Location..... Leonardtown Maryland

18. Funeral director..... W. C. Martin & Sons

Address..... Leonardtown Maryland

19. Date rec'd by registrar..... 11/3/48

(Date rec'd by registrar) 19.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 2d 1948 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 17 1943 to Nov. 2d 1948

and that I last saw him alive on Oct. 2d 1948

Immediate cause of death..... Acute fibrillation

Untricular (of heart) DURATION..... 10 min.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

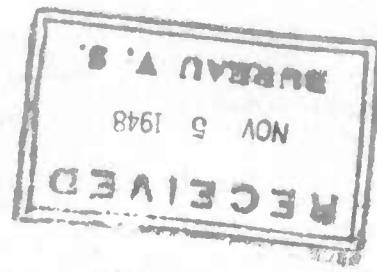
Means of injury.....

Injured at work?

23. SIGNATURE..... J. T. Greenwell

M. D. or other

Address..... Leonardtown Maryland Date signed. 11-2-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11734

167

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County *St. Mary's*
City or town *Mechanicsville* MD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Louis BENEDICT MILES

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male Colored single

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

December 6, 1926

8. AGE:

Years	Months	Days	11 less than one day
22			hrs. min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Decreasd

MOTHER FATHER

12. Name

Decreasd

13. Birthplace

"

14. Maiden name

Decreasd

15. Birthplace

"

16. Informant

John J. Miles

Address

Leonardtown, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Joseph

Location

Morganza, Md.

18. Funeral director

J. B. Robinson

Address

Leonardtown, Md.

19. Date rec'd by registrar

16/13 48 Casualties

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *A. Mary's*City or town *Mechanicsville*
(If outside city or town limits, write RURAL and give nearest town)Street No. *C*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

1 Nov 1948

19.48 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

23 Oct 1948 to 1 Nov 1948

19.48

and that I last saw him alive on

1 Nov 1948

19.48

Immediate cause of death

Subdural Hematoma

DURATION

*10 d.*Due to *Penetrating knife wound of head**10 day.*Due to *bleed*

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Penetrating knife wound of skull.

Date of op.

Autopsy results *Penetrating knife wound of skull.*

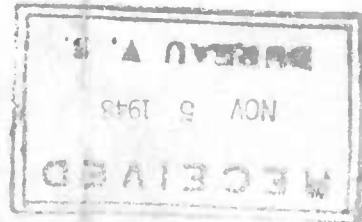
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Homicide* Date of *10/29/48*Where did injury occur? *Mechanicsville St. Mary's* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *Public place (Tavern)*Means of injury *Knife wound* Injured at work? *No*23. SIGNATURE *Roy G. Guther, M.D.*

M. D. or other

Address *Mechanicsville* Date signed *Nov 1948*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11735
1825

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

James Edward Newton

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Male white married

6. (b) Name of husband or wife..... Ruth E. Newton

7. Birth date of deceased (mo., day, yr.)..... Aug 25 - 1869

6. (c) If alive, give age..... 73 years

8. AGE: Years..... 79 Months..... 2 Days..... 19 hrs..... min.....

9. Birthplace..... Holly Wood St Mary Md

(Town, county, and state)

10. Usual occupation..... Carpenter

11. Industry or business

12. Name..... Franklin Newton

13. Birthplace..... St Mary Co

14. Maiden name..... Isabella Yallow

15. Birthplace..... St Mary Co

16. Informant..... Mrs. Shulma Mc Gee

Address..... Holly Wood Md

17. Burial..... Date thereof..... Nov 17 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St John Cemetery

Location..... Holly Wood Md

18. Funeral director..... W. G. Martingay Sons

Address..... Leonardtown Md

19. (Date rec'd by registrar)..... 11/16/48

(Date rec'd by registrar)..... 11/16/48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St Mary

City or town..... near Holly Wood

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 17 - 1948 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that attended deceased from

Rue 1948 to Nov. 15 1948

and that I last saw him alive on Nov. 14 1948

Immediate cause of death.....

Cardio-Vascular Disease Death year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Frank A. Cerasale

M. D. or other..... Foreman

Date signed..... 11/16/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11736

CERTIFICATE OF DEATH

182
Reg. Dist. No.

282

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

—

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 24 1948

6.(c) If alive, give age... years

8. AGE:

Years Months Days If less than one day hrs. min.

1

28

.....hrs.min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Mrs. Harry Morris

13. Birthplace

Md

14. Maiden name

Patricia Ann Merely

15. Birthplace

D.C.

16. Informant

Mrs. Mamie J. Thrift

Address

Leonardtown

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 11/22/48
(month) (day) (year)

Cemetery or crematory

St. Mary's Cemetery

Location

Leonardtown Md

18. Funeral director

W.L. Macneigh Jr.

Address

Leonardtown Md

19. Date rec'd by registrar

11/21 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

Count

City or town

Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 21 1948 at 8:30 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 21 1948 to

and that I last saw him alive on Nov 21 1948

Immediate cause of death

Suffocation

Due to

Face buried in pillow

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Name of injury

injured at work?

Signature

M. D. or other

Address

Date signed 11/21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11737

185

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:
County..... St. Marys
City or town..... Naval Air Station, Patuxent River, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 18 months
Hospital, institution, or street address where death occurred:..... Dispensary, US NAS, Patuxent River, Md.
How long in hospital or institution?..... 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys
City or town..... St. George Island, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No..... none
(If rural, give LOCATION)

3. (a) FULL NAME

POE, William Clarence

4. Sex..... Male	5. Color or race..... White	6. (a) Single, married, widowed, or divorced..... Single
------------------	-----------------------------	--

6. (b) Name of husband or wife.....
7. Birth date of deceased (mo., day, yr.)..... 5-14-47
6. (c) If alive, give age..... years

8. AGE: Years..... 1	Months..... 6	Days..... 5	If less than one day hrs.....	min.....
----------------------	---------------	-------------	----------------------------------	----------

9. Birthplace..... Leonardtown, StMarys, Maryland
(Town, county, and state)

10. Usual occupation..... ---

11. Industry or business..... ---

MOTHER FATHER
12. Name..... Clarence William Poe
13. Birthplace..... Maryland

14. Maiden name..... Elva Kathleen Graves,
15. Birthplace..... Washington, D. C.

16. Informant..... Mother
Address..... St. George Island, Maryland

17. Burial..... Burial Date thereof..... Nov 22 1948
(Burial, cremation, or removal; Which?) (month) (day) (year)

Cemetery or crematory..... St Francis Xavars
Location..... St George Island Md

18. Funeral director..... W C Matherly Jr
Address..... Leonardtown Maryland

19. (Date rec'd by registrar)..... 11/20 48

3. (b) Social Security Number..... ---

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19 November 19 48 at 12:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 November 19 48 to 19 November 19 48 and that I last saw him alive on 19 November 19 48

Immediate cause of death..... Respiratory Failure

Due to..... Foreign body in Trachea ---

Due to..... (1 hr
(30 min)

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Tracheotomy
Sucker stick in Trachea Date of op. 11-18-48

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of 11-18-48

Where did injury occur?..... St. George Isld, St. Marys Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Home

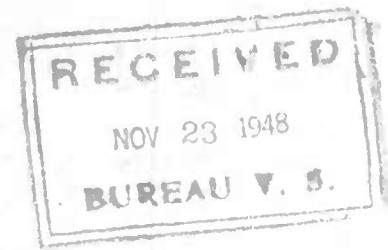
Means of injury fell with sucker in mouth injured at work?

Frank D. Virgilio

23. SIGNATURE..... FRANK D. VIRGILIO, LCDR, MCR, USNR
M. D. or other

Dispensary Address..... NAS, Patuxent River, Md. Date signed 11-19-48

Registrar



I The correct age
is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11738

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH:

County *ST. MARY'S*
City or town *C. CHARLOTTE HALL (RURAL)*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

ROLLINS, Mary Florence

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband

Marcellus R. Rollins

7. Birth date of deceased (mo., day, yr.)

June 18, 1890

6. (c) If alive, give age years

8. AGE: Years

*58**4**15*

Months

*hrs.**min.*

Days

9. Birthplace

Mechanicsville, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name *Geo. Henry Turner*13. Birthplace *Riverside, Md.*14. Maiden name *Catherine Ann Brown*15. Birthplace *Riverside, Md.*

16. Informant

*Marcellus R. Rollins*Address *Mechanicsville, Md.*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof *11/15/48*

(month) (day) (year)

Cemetery or crematory

Trinity

Location

Newport, Md.

18. Funeral director

Hunt & Major

Address

Waertor, Md.

19. Date rec'd by registrar

Nov 3 1948

(Date rec'd by registrar)

Eleanor Carter

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *MARYLAND* County *ST. MARY'S*City or town *RURAL NE C. CHARLOTTE HALL*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

2 Nov 1948 at *2³⁰ P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 May 1948 to *2 Nov 1948*and that I last saw her alive on *2 Nov 1948*

Immediate cause of death

Cerebral embolism

DURATION

*1 day*Due to *Pneumocytic carditis**Vascular disease with*Due to *mitral stenosis*Other conditions *Hypertension*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ray Guyther, M.D.

M. D. or other

Address *Mechanicsville*Date signed *2 Nov 48*



IM
Age
Live correct ageC
CountyT
City or townH
How long in above place of death?H
Hospital, institution, or street address where death occurred:I
How long in hospital or institution?F
How long in hospital or institution?N
Name of husband or wife.B
Birth date of deceased (mo., day, yr.)A
Age: Years Months Days If less than one day hrs. min.B
Birthplace (Town, county, and state)O
Usual occupationI
Industry or businessF
NameB
BirthplaceM
Maiden nameB
BirthplaceI
InformantA
AddressB
Burial, cremation, or removal, Which?C
Cemetery or crematoryL
LocationF
Funeral directorA
AddressD
Date rec'd by registrar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11739

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 12/48

8. AGE:

Years

Months

Days

If less than one day

hrs. 1 min.

9. Birthplace

Died

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Jos. Deon J. Russell

13. Birthplace

Died

14. Maiden name

Sarah Anna Ahey

15. Birthplace

Died

16. Informant

Jos. Deon J. Russell

Address

Newbernville

17. Burial, cremation, or removal, Which?

Buried Date thereof "11/12/48"

(month) (day) (year)

Burying or crematory

St. Joseph's

Cemetery or crematory

McGaw's

Location

Died

18. Funeral director

Jos. Deon J. Russell

Address

The Newbernville

19. Date rec'd by registrar

11/12/48 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

Ind

County

St. Marys

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 12 1948 11:36 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 12 1948 to Dec. 12 1948

and that I last saw him alive on Dec. 12 1948

Immediate cause of death

Neurocephalitis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank A. Cavalier M. D. or other

Address

11/12/48 Date signed

RECEIVED

NOV 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11740

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County: St. Marys
 City or town: near Clements, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Martha A. Russell

4. Sex: Female 5. Color or race: White 6. (a) Single, married, widowed, or divorced: Widowed

6. (b) Name of husband or wife: Jackson Russell

7. Birth date of deceased (mo., day, yr.): Oct 2 - 1864 6. (c) If alive, give age: years

8. AGE: Years: 84 Months: 1 Days: 2 If less than one day: hrs: . min: .

9. Birthplace: Clements, St. Marys, Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Tailor

12. Name: Edward J. Rose

13. Birthplace: St. Marys Co.

14. Maiden name: Edwards

15. Birthplace: St. Marys Co.

16. Informant: Edwin Russell

Address: Clements, Maryland

17. Burial: Date thereof: Nov 6, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory: St. Joseph Cemetery

Location: St. Joseph, Maryland

18. Funeral director: W. C. Mathisley Son

Address: Leonardtown, Maryland

19. Date rec'd by registrar: 11/5/48

Counselor

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St. Marys

City or town: near Clements
(If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov - 4 - 1948 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 9 1948 to Nov 4 1948

and that I last saw her alive on Nov 4 1948

Immediate cause of death:

Cardiac respiratory failure

Due to: Cardiac failure

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

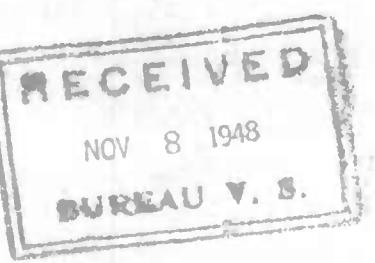
Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Roy G. Guther, M.D.

M. D. or other: Greenwell

Address: Date signed: Nov 5/48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11741

CERTIFICATE OF DEATH

Reg. Dist. No. 286

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Sarah Frances Russell

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

W WIDOWED

6.(b) Name of husband or wife.....

John Henry Russell

7. Birth date of deceased (mo., day, yr.)

12-30 1870

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

77 10 7 hrs. min.

9. Birthplace.....

Clementine Springs Md

(Town, county, and state)

10. Usual occupation.....

House keeper

11. Industry or business

Farms Hay deer

12. Name.....

Eliezer C. E. and

13. Birthplace.....

Missouri Bowles.

14. Maiden name.....

Sarah co

15. Birthplace.....

Baltimore

16. Informant.....

Joseph Russell

Address.....

Clinton Md

17. Burial, cremation, or removal. Which?

Date thereof..... 11-8-48

(month) (day) (year)

Cemetery or crematory.....

Sacred Heart

Location.....

Bushwood Md

16. Funeral director.....

McMullings Sons

Address.....

Lew and Lora

17. Date rec'd by registrar.....

19-11-18 R. S. Palmer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 11-8-48 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-12-18 to 10-11-48, 1948,

and that I last saw her alive on 11-7-48, 1948.

Immediate cause of death.....

DURATION

sudden death

Due to cerebral disease

of heart

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed 11-11-48



11742

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.

(If rural, give LOCATION)

3. (a) FULL NAME

Alma Elizabeth Wathen

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

Joseph C Wathen

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age

years

Nov 5 - 1886

8. AGE:

Years

Months

Days

If less than one day

62

-

13

hrs.

min.

9. Birthplace

(Town, county, and state)

Hollywood St Marys Md

10. Usual occupation.....

House Wife

11. Industry or business

MOTHER FATHER

12. Name.....

Wallace Abel

13. Birthplace

St Marys Co

14. Maiden name.....

Anna Clarke

15. Birthplace

St Marys Md

16. Informant.....

Joseph C Wathen

Address

Leonardtown Md

17. Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

St Andrews

Location.....

Leonardtown Md

18. Funeral director.....

W C Mattingley Son

Address

Leonardtown Md

19. (Date rec'd by registrar)

Cecilia

11/18 48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 17

1948 at 3:14 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 30 1947 to Nov 17

1948

and that I last saw him alive on

Immediate cause of death.....

Fibrillation of heart

DURATION

3 min

Due to.....

Chronic Pulmonary

Disease

3 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

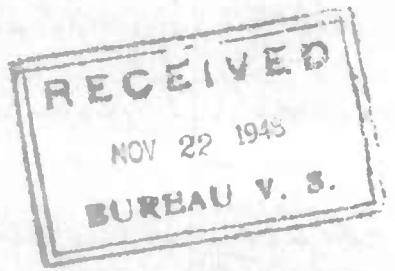
P. J. Greenwell

M. D. or other

Address.....

Leonardtown

Date signed Nov 18 1948



11743

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH

County

St. Marys

City or town Leonardtown Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 hours

Hospital, institution, or street address where death occurred:

St. Marys Hospital

How long in hospital or institution? 17 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County St. Marys

City or town Hedges Wood

(If outside city or town limits, write RURAL and give nearest town)

Street No. A. 7. P. 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Walter Leonard Woodburn

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

married

6. (b) Name of husband or wife

Mrs. Walter L. Woodburn

6. (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.)

Jan 17 - 18 89

8. AGE:

Years
59Months
10Days
16If less than one day
hrs. min.

9. Birthplace

Compton St. Marys Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

some

12. Name

Hobbs Woodburn

13. Birthplace

St. Marys Co

14. Maiden name

Sueie Grimes

15. Birthplace

St. Marys Co

16. Informant

F. Abell Woodburn

Address

Leonardtown Maryland

17. Burial

Burial

Date thereof Jan 3 1948

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Our Lady's Chapel

Location

Leonardtown Maryland

18. Funeral director

W. C. Hartley Son

Address

Leonardtown Maryland

19. (Date rec'd by registrar)

11/2 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 1 1948 at 1:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 31 1947 to Jan 1 1948

and that I last saw him alive on Jan 1 1948

Immediate cause of death

Diabetes on dorsal coma

Due to Diabetes

Due to

Other conditions

Endocrin disease

right

(Include pregnancy within 3 months of death) 1 month

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

(R. Gaynor)

Injured at work?

23. SIGNATURE

M. D. or other

Address Leonardtown, Md. Date signed 11/1/48

